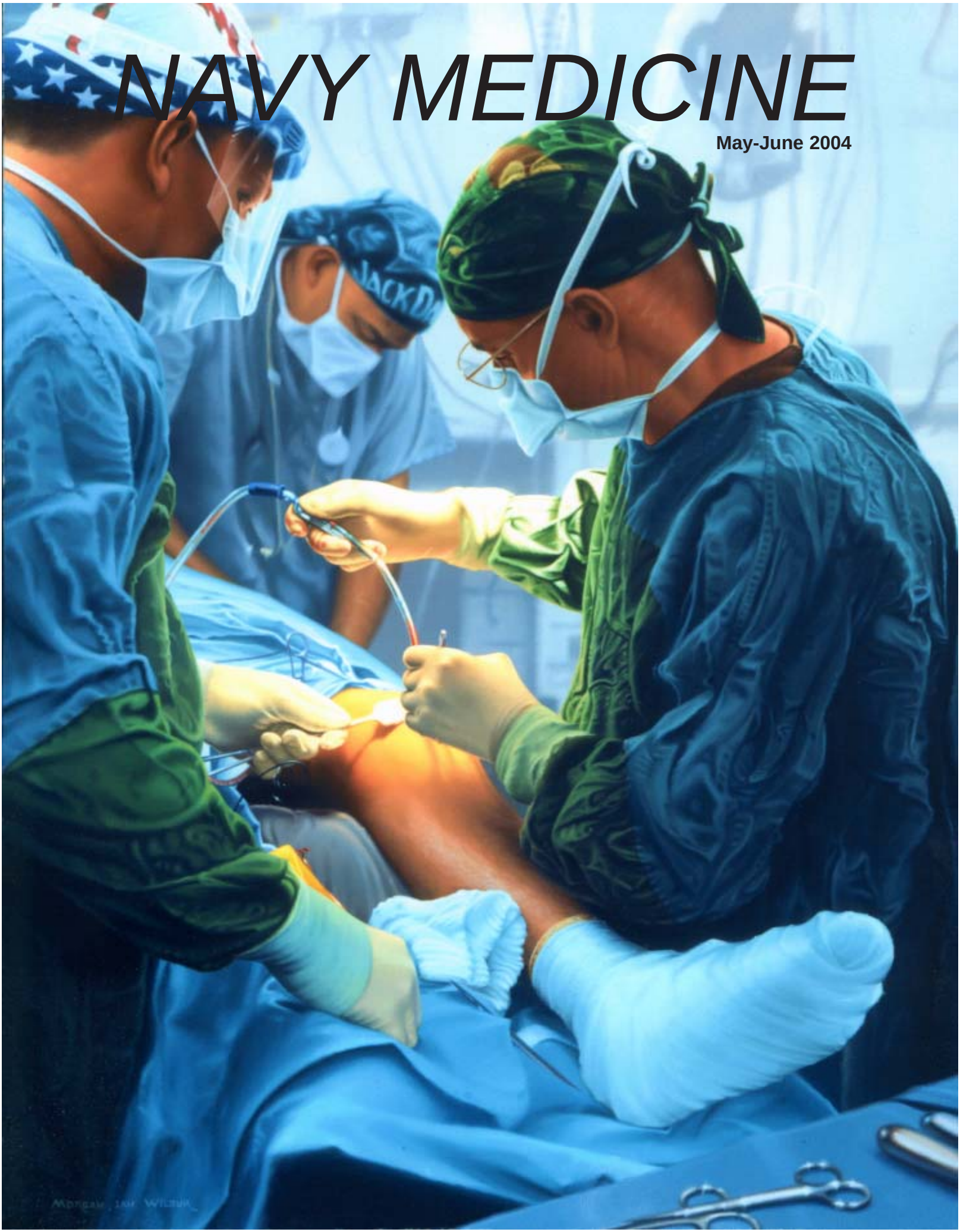
NAVY MEDICINE

May-June 2004



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Cover: Surgeons work to remove shrapnel from a hospital corpsman's knee at Fleet Hospital 3 in southern Iraq during Operation Iraqi Freedom. This operation is depicted in a new painting by Navy artist Morgan Wilbur. Story on page 5. Painting from the Naval Historical Center.

Navy EMF Portsmouth Has the Con

JO1 Daniel A. Bristol, USN

As the morning sun shines through the windows of the Camp Doha gymnasium, pride shines in the eyes of both Sailors and Soldiers alike. The Soldiers stood the watch for nearly a year and are ready to be relieved. The Sailors stand tall and proud in formation ready to start their day and their mission, but this isn't just any mission; this one will go down in history.

Personnel from Navy Expeditionary Medical Facility Portsmouth marked their page in the history books as they relieved the Army 801st Combat Support Hospital in a Transition of Authority Ceremony held 1 April. This is the first time a Navy medicine unit has taken on this type of assignment, which is part of the largest troop rotation since World War II.

Commander, 801st Combat Support Hospital, COL Craig Bugno passes operational control over to commanding officer, Navy EMF, CAPT Martin Snyder.

"These Army Soldiers have given their support to the war on terrorism and to their country," states Commander, 8th Medical Brigade, BGEN Michael Walter, guest speaker at the ceremony. Walter said the Soldiers of the 801st have given their best to ensure the best medical attention was given to those who needed it. He said it is time for these Soldiers to go back home and thank their families for all of their support throughout their tour.

"Today is the first day of the 12th month the soldiers of the 801st have been in Kuwait," said Bugno. "Today we transfer authority of the hospitalization mission in Kuwait to EMF Portsmouth."

As HN Taylor Crump grasped the flagstaff, HMCS(SW/FMF) Tony Polanco, senior enlisted leader, Navy EMF, assisted with the uncasing of the Navy flag. Salutes were rendered between Snyder and Walter to mark the beginning of the Navy mission. With the removal of the Navy flag from its casing, Bugno and Walter began rolling the flag of the 801st, signifying the completion of its mission in Kuwait.

"Our current surgeon general, VADM Michael Cowan, coined the phrase, 'Muddy Boots'," explained Snyder. "It was his goal to instill in the minds of Navy medical personnel that their focus should be on those Sailors, Marines, and Soldiers who wear the muddy boots. I think that is truly fitting here in Kuwait. Although the mud may be sand, the mission is still the same.

"We have the unique opportunity to execute a sustainment mission," continued Snyder, "which directly supports the United States Armed Forces and Coalition Forces in the global war on terrorism. This is a mission that is unprecedented, as Navy medicine has not ventured into the arena of medical sustainment."

"CAPT Snyder and members of the EMF—I am confident that you can get the job done," said Walter, "and I look forward to working with you all in the upcoming year."

Said Snyder, "I know that I speak for the entire Navy Expeditionary Medical Facility when I say that we are honored to be a part of history. We will courageously execute our mission, and we are committed to providing the best medical support to the Coalition Forces. Although it appears many changes are ahead," continued Snyder, "the 801st Combat Support Hospital has laid the groundwork in providing optimal, quality care to our service men and women and has established wonderful relationships with the Kuwaitis—just two things we hope to continue and to build on. We wish for you the strength, courage, and honor that sustained us," Bugno added. "We leave knowing the quality, drive, and determination of our replacements in this mission remains. We wish you well."

"In the tradition of the U.S. Navy," explained Snyder, "Colonel, I wish you and the 801st Combat Support Hospital fair winds and following seas. I have the con, you stand relieved."

Navy EMF Portsmouth officially kicked off its deployment to Kuwait on Super Bowl Sunday 1 February. Fifty more members departed over the Valentine's Day weekend from the Norfolk International Airport. The final 130 members of EMF departed from the Military Airlift Command Terminal at Norfolk Naval Station on 12 March. A second wave of EMF deployers is being identified to relieve the first wave at some point in August or September. EMF will stand the watch in Kuwait for 1 year. ❑

JO1 Bristol is Public Affairs Officer at Naval Medical Center, Portsmouth, VA.

* * *

Robert E. Mitchell Center Provides Evaluations for Repatriated Prisoners of War

LTJG William R. Berg, MSC, UNSR

The Robert E. Mitchell Center (REMC), part of the Naval Operational Medicine Institute (NOMI) provides comprehensive annual physical and psychological evaluations for Repatriated Prisoners of War (RPOW), members of a matched comparison group, and families of RPOWs to determine the long-term effects of the POW experience.

Combat-Related Special Compensation (CRSC) is an entitlement created by section 636, Public Law 107-314 effective 1 June 2003. The REMC recently began providing both background and specific information to help the Naval CRSC Branch adjudicate former POW CRSC applications. CRSC provides benefits to certain retirees with combat-related (CR) disabilities that qualify under the criteria of the law. The CRSC Branch of the Naval Council of Personnel Boards processes applications and determines eligibility for Navy and Marine Corps retirees.

www.nomi.med.navy.mil

Robert E. Mitchell RPOW Center

To qualify, retirees must have either Purple Heart injuries that combine to at least 10 percent, or combat-related injuries that combine to at least 60 percent. They must also meet all of the following requirements:

• Have 20 years of service creditable for the computation of retired pay or, 7200 reserve points for computation of retired pay.

• Currently in a retired status.

• Entitled to retired pay (includes retirees who have waived military retired pay in order to receive VA disability compensation).

• Awarded the Purple Heart and have a combined disability of at least 10 percent or, if not awarded the Purple Heart, have a combined disability rating of at least 60 percent.

DOD estimates receipt of approximately 22,000 applications from the existing population of retirees between June 2003 and June 2005.

Additional information is available on the CRSC page on the Naval Council of Personnel Boards website at www.hq.navy.mil/ncpb. ❑

LTJG Berg is Department Head, Administration Duty Station, Naval Operational Medicine Institute, Pensacola, FL.

Claimancy 18 Facility Updates

James R. Brassfield

It is again time to provide BUMED and our activities with an update on facilities improvements throughout our claimancy. Several hospital projects have been completed recently, not the least of which is a new 20-bed hospital and dental center at Naples, Italy. Located at the new support base at Grichignano, this project offers a long needed improvement to the leased facility we once occupied. The Navy support mission has now completely relocated from Agnano, and service members and their families can now enjoy, in addition to the new hospital, new housing, schools, MWR activities, and even a village forum designed and built in a style suitable to the Italian environment. Also in Italy a new Flight Line Clinic has been completed at NAS Sigonella.

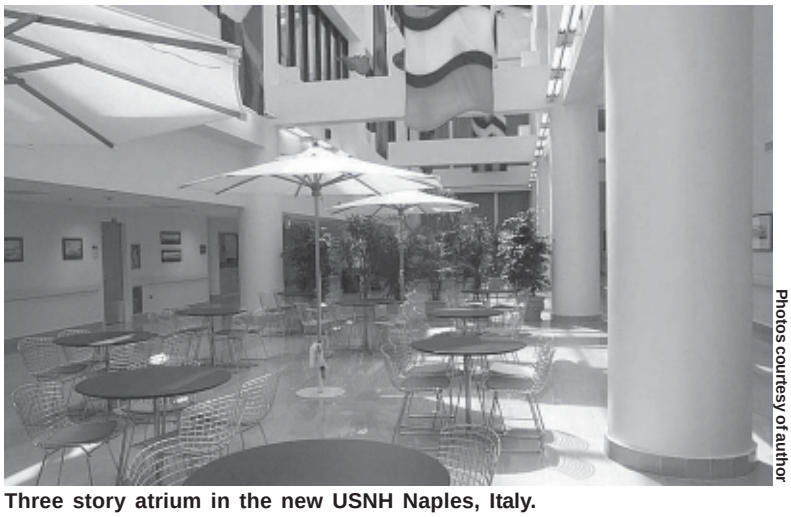
Major additions and alterations have been built at Naval Hospitals Pensacola and Bremerton. These projects offer new spaces for outpatient care as well as modifications to ancillary departments and inpatient areas. Parking enhancements were also included.

Five troop clinics have been built for the Marine Corps at Camp Pendleton. Area camps at Margarita, San Mateo, Horno, Las Pulgas, and Flores all have new medical and dental clinics sized to their mission, replacing older buildings which were returned to the Marines. Also at Camp Pendleton is a new Fleet Hospital Operational Training Center which provides for conference and training space for the fleet hospital mission previously offered in modular buildings.

The aviation community can now be trained in new Aircrew Water Survival Training Centers. These new training pools accompany Aviation Physiology Training Units which were completed earlier after BUMED inherited this aviation training mission from the line Navy in 1994. These training facilities are located at Patuxent River, Cherry Point, Norfolk, Pensacola, and Whidbey Island.

The preventive medicine community has a new Disease Vector Ecology and Control Center at Bangor, WA. We also have MILCON programs for future replacement Environmental Preventive Medicine Units at Sigonella and Pearl Harbor. The Sigonella project will start design this year, to be followed next year by Pearl Harbor.

Our Corps School at Great Lakes has a laboratory expansion for its students. A Great Lakes Naval Ambulatory Care Clinic (NAC) replacement is also in the planning stages as a sharing agreement with the adjacent Vet-



Photos courtesy of author

Three story atrium in the new USNH Naples, Italy.

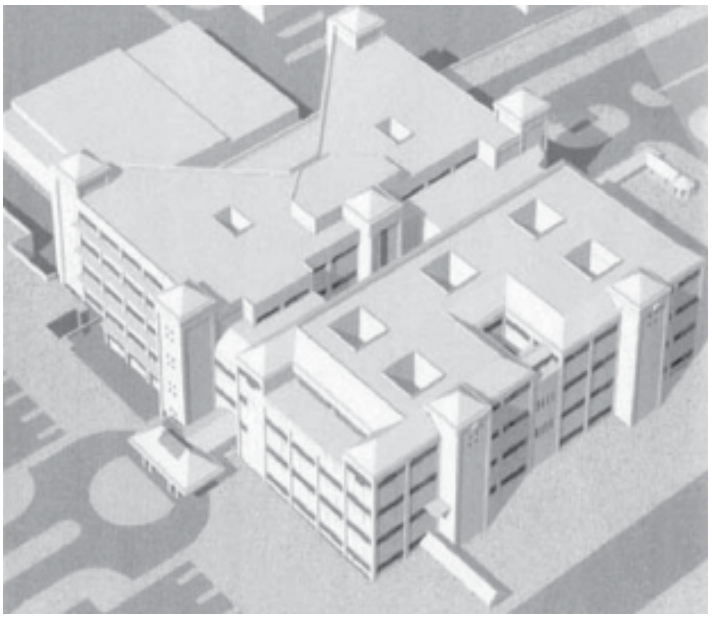
erans Affairs facility. Much planning is underway for this NAC in order to properly integrate required improvements for both the Navy and the VA on the North Chicago VA campus.

A new clinic has recently opened at the Marine Corps Logistics Base in Albany, GA, and a similar but much larger facility is nearing construction completion at Naval Station Mayport, FL. Also, awarded for construction is a major addition and alteration project at Sewells Point in Norfolk in direct support of the Navy mission at that East Coast center.

This year advertisement for construction of two clinics is anticipated. A new dental clinic has been designed for Groton, CT. And a renovation of a historic building at the Washington Navy Yard will provide expanded and enhanced medical and dental services for NAVSEA and other users at that station.

In various stages of design are clinics at Parris Island, Diego Garcia, Charleston, and Bahrain. A new academic center and graduate school of nursing is under design for the Uniformed Services University of the Health Sciences in Bethesda. And another major addition/alteration project is planned for Naval Hospital Jacksonville, which was expanded several years ago.

New main entrance for Naval Hospital, Bremerton, WA.



Architectural rendering of the proposed replacement for USNH Okinawa.

Finally, the Government of Japan is seriously considering the replacement of the hospital complex at Okinawa. At the previous direction and agreement between our two countries, the Navy will leave the current hospital at Camp Lester and relocate to a site at Camp Foster once the new facilities design has been finalized. Some of these new facilities could be completed and occupied by the year 2008. ❑

Mr. Brassfield is Deputy Director and Chief Architect, Facilities Division (M33B), Bureau of Medicine and Surgery, Washington, DC.

Combat Surgery in Iraq Captured in Original Art

An original oil painting depicting combat surgery in Southern Iraq was unveiled and presented to the Surgeon General of the Navy at the Bureau of Medicine and Surgery on 12 March.

VADM Michael L. Cowan accepted the painting on behalf of Navy medicine from Morgan Ian Wilbur, a Navy artist who spent 8 days in the desert with Fleet Hospital Three (FH-3) in April 2003 during Operation Iraqi Freedom (OIF). Wilbur was commissioned by the Naval Historical Center to complete a series of paintings and sketches illustrating the lifesaving capabilities of Navy medicine.

"I accepted an assignment to do some paintings of corpsmen, doctors, and nurses who were working on the battlefield. The subject interested me, but I didn't know exactly what I would see," said Wilbur. "What I saw was their tireless efforts and the experience changed my life. It changed my personal life and the direction my art is going. Watching these people work under such harsh conditions, in the heat, and during sand storms, treating the wounded and sick, combatants and noncombatants alike, is an experience that I will keep with me for the rest of my life. I just hope my painting reflects what really went on there."

FH-3 became part of Navy history as Navy medicine's first Expeditionary Medical Facility deployed to a war zone on 25 March 2003. The 116-bed facility covered 9 acres and was supported by about 300 Navy personnel. During OIF the staff took care of over 1,100 patients (coalition forces, displaced civilians, and enemy prisoners of war) and performed over 620 surgical procedures.

"It was a great opportunity to have Morgan with us in southern Iraq," said CAPT Peter F. O'Connor, MSC, commanding officer of FH-3. "We were excited to have him capture the essence of what it was like in a way that would be displayed for years to come, for future generations too see."

When Wilbur removed the drape in front of his painting and presented it to VADM Cowan, the audience in the Rotunda at BUMED sat silently for a long moment, then the room filled with a long and loud applause.

"What a wonderful painting!" said Cowan with heartfelt emotion. "Art has a way of revealing a part of ourselves and does it in a way that no other medium can capture. I am very grateful that there is someone among us who was born with this talent, who spent a lifetime developing that talent to eventually make this kind of representation of our professional lives. Because of this painting, generations of Americans will remember what we did. Morgan, thank you so much for your work, and I accept this on behalf of Naval medicine."

The painting will be displayed at BUMED for 1 month, and then returned to the Naval Historical Center. When Wilbur has completed his FH-3 series, the collected works will tour the U.S.

Wilbur's work is also represented in the collections of the Smithsonian Institution's National Air and Space Museum and the National Oceanographic and Atmospheric Administration. His works have also been exhibited at the National Museum of Naval Aviation, Pensacola, FL, and the Navy Art Gallery, Washington, DC.❑

—Story by Doris M. Ryan, Public Affairs Officer (M00P1), Bureau of Medicine and Surgery, Washington, DC.

Charlie Med
A Physician's Vietnam Journal

CAPT William B. Mahaffey, MC, USN (Ret.)

Part I

Are you sitting down? I have some interesting news for you." The voice on the phone was CDR Tweedie Searcy, NC, one gem of a nurse anesthetist at Portsmouth Naval Hospital located in Virginia's historic Hampton Roads.

It was an early October evening, 1965. I had only recently moved into my One Crawford Parkway studio apartment overlooking the Elizabeth River where I had just watched a massive aircraft carrier inching its way from Norfolk Naval Shipyard. From my 16th floor balcony I could look a half-mile to my left and see my very first Navy duty station, Portsmouth Naval Hospital, where I had been stationed since I commenced active duty in July 1965. My early "gung ho" Navy spirit sometimes manifested itself at home in the evenings much as it did at work in the daytime. From my balcony each evening, I would often observe the Evening Colors ceremony as several hospital corpsmen ceremoniously lowered the United States flag in front of the hospital. Later in the evening, I could return to my balcony to hear the "2100 Cannon" fired from in front of the Marine Barracks at nearby Norfolk Naval Shipyard. From the Navy"s early days in that area, the "2100 Cannon" had been fired nightly so that ships in the area could set their chronometers.

This wet-behind-the-ears physician had only recently made the awkward transition from unregimented civilian life and residency training in anesthesiology at Ohio State University Hospitals to the regimentation and historic traditions of Navy life at Portsmouth Naval Hospital (NAVHOSP PORTSVA). I saluted a few Navy chiefs during those early days. They returned my salutes, delaying any inevitable smiles until we had passed. During my first week on active duty, I had changed into dress khakis one day to have my official photograph taken. I mistakenly continued to wear my khaki cap cover, to the amusement of salty veterans who saw me after I had changed back into my every day "tropical whites," the working uniform in a naval hospital.

Tweedie Searcy, and her good friend LCDR Bobbi Hovis, NC,(*1,2*) were pioneers in the Navy's presence in Vietnam. Tweedie and Bobbi had already returned from a tour of hazardous duty at the U.S. Naval Hospital in the Saigon area when I first met them at Portsmouth Naval Hospital. I quickly adopted Tweedie as a fine friend and advisor during my initial days on active duty in the Navy, and I cherish Tweedie's and Bobbi's continuing friendship to this day.

What news could Tweedie, the hospital's anesthesia watch-stander that night, possibly have for me that would justify her interrupting my TV dinner while I watched the evening news? Puzzled, I did sit down while Tweedie told me that she had just had supper with CAPT Summerour, the hospital's senior pharmacy officer. As the Officer-of-the-Day (OOD), he had access to incoming Navy message traffic. He had informed Tweedie that he had seen incoming orders for a LT William B. Mahaffey, MC, USNR (Me!) to report as an anesthesiologist to the Medical Battalion, Marine Division [PORICH.] "PORICH" was current Navy message lingo for "whichever port the unit might be in."

Overflowing with youthful naivete, I drove the short distance to the Naval Hospital that evening and asked someone in the OOD's office which port the Third Medical Battalion might

Photos courtesy of author

Original C-Med OR, January 1966.

be located in. A Navy chief on duty that evening told me that the Third Medical Battalion or at least its "C" Company or Charlie Company, was the well-known and much-respected "Charlie MED", a primitive field hospital of sorts manned by Navy medical personnel in support of Marine operations in the field. He led me to believe that it was actually located in Okinawa. To a Navy neophyte with a developing wanderlust, Okinawa sounded like a young traveler's dream come true. My only foreign travel at that time had been the briefest of trips across the borders into Mexico and Canada. As a naval reservist, I had only a 2-year obligation to the Navy. What an opportunity it would be to spend the remainder of those 2 years on far away Okinawa! I visited the crew's library in the hospital that evening, and checked out their one small book on Okinawa.

In days to come, my naivete gave way to realism. I was required to have my last will and testament drafted. I needed a will? I had just turned 29! I got all of my immunizations. I was outfitted with Marine Corps, (heavy greenish combat uniforms) and combat boots. What was I going to do with the ceremonial Navy sword I had just purchased? I had to arrange to have my few household effects placed in "non-temporary storage," rather than shipped to that villa of my fantasies on Okinawa. I then learned that the fine print in my orders would first have me spending 2 weeks, *en route* to someplace over there, at Camp Pendleton, CA, as a student in the Navy's Field Medical Service School (FMSS) which was tasked with preparing Navy medical personnel to serve with the Marines overseas.

At NAVHOSP PORTSVA, I had learned what a superb team the members of the Navy's medical department can be. I had quickly developed an immense love for Virginia's Hampton Roads or "Tidewater." By early November, I had said my fond farewells to my new friends at Portsmouth and headed for Columbus, OH, for a weekend with family and an Ohio State football game. Then I was off to Camp Pendleton in my year-old $2,100 Ford Mustang, though I had no idea what I was supposed to do with my Mustang once I finished my 2 weeks at FMSS. I still owned up to only a faint idea of where I was ultimately heading.

With my few belongings stashed away in my Mustang, I arrived at Camp Pendleton late in the afternoon of 10 November 1965, the Marine Corps Birthday, a hallowed holiday on the Marine calendar. Before I left Portsmouth, one of the corpsmen had urged me to spare no effort in finding out what the term "BAM" meant as soon as I got to Camp Pendleton. A gruff female enlisted Marine, whose arm bore a number of chevrons that meant nothing to me, checked me in to Field Medical Service School. I wasted no time in asking her if she knew what "BAM" meant. When she wrinkled her brow, I added, "I was

told to ask!" She retorted, "It means 'Broad-Assed Marine,' Sir. It's a term that Marines are no longer allowed to use when referring to us women Marines. I think someone has put you up to this!"

The next day was down to business. The school's mission was to teach us how to practice medicine in a combat zone, but they were still teaching primarily cold-weather medical principles from Korea. We had to disassemble and then reassemble a .45 pistol. It would be our personal weapons of defense in Vietnam, we were told. Someone had finally said the word "Vietnam." Is that where we were really headed? And we had physical fitness challenges I had never imagined. While supervised by real Marines, we had to run, run, run! I had enjoyed running track in high school, but I had never run with a backpack and while wearing heavy combat boots before. We had to do the broad jump, something I had never attempted! And, for some reason, we had to climb a long 1-inch rope, a bizarre skill I would apparently need in order to practice anesthesia wherever they were going to send me. I had no idea how to climb a rope and never got my feet off the ground.

Then we experienced one of our night exercises when what seemed like a thousand real Marines with flares and dummy ammunition successfully surrounded and overtook the hill that we physicians, dentists, and chaplains had been "defending" in Camp Pendleton's rain and fog. But during those exercises we learned an important bit of Marine philosophy: One of an officer's many responsibilities is to ensure that the enlisted troops are secure and well fed.

After completing FMSS, I had several days to get to the Navy's Treasure Island Transit Quarters near San Francisco in preparation for catching a flight west out of Travis AFB a few days later. I faced reality and found a place near Oakland where I could store my car commercially for a year. But until I actually placed my car in storage, I was "wheels" for several of us from FMSS who were to fly out from Travis AFB together. We had most of a week to kill before our flight so we took in San Francisco's sights and visited the redwoods. Then, at a dentist's urging on that final night before I stored my car, we visited The Peppermint Tree Lounge, a topless bar in San Francisco where stripper Carol Doda, slithered and crooned altogether in the buff (almost!) on her white ermine-covered couch. It was fake ermine, I'm sure. Probably rabbit. Once I realized that I could look directly at the topless waitresses, I was impressed by how <u>un</u>voluptuous they really were!

Finally we were on the bus to Travis AFB and soon winging our way to Okinawa. Still uncertain of our schedule and final destination, we were lodged in Marine dorm-style transit quarters. That evening, we explored downtown Naha, Okinawa, and sampled tofu, or bean-curd cubes. I haven't eaten tofu since that night.

We had several days to kill on Okinawa. Then one evening, we were informed that our departures were scheduled. Early the next morning we mustered to be briefed for our flight later that morning to Danang Air Base in Vietnam.

In a downpour, we boarded the Marine C-130 aircraft in Okinawa. Most of our hundred or so fellow passengers were enlisted Marines barely out of high school. We Medical Department officers and chaplains were addressed with saccharine "respect," yet hidden in that verbiage was already a trace of the genuine respect which the Marine reserves for Navy medical personnel who serve in the field with them. Following a tour with the Marines in Vietnam, I would learn that this profound respect is not only mutual but is also most enduring.

Communications with the young "real Marines" on the passenger manifest that day were more blunt. They were told, "Marines never puke, but if you're gonna puke, puke in your helmet, not on the deck! Is that understood?"

The stormy skies were turbulent during most of the flight to Danang Air Base. No one puked. Our in-flight meal service was a disappointing brown-bag lunch and a warm soda. Just before landing, the Marine pilot briefed us on the arrival routine. I don't know if he was a Vietnam combat veteran or simply a fixed-wing pilot who had been spared ground combat duty, but he was unusually sincere in his wishes for our safety and well being in Vietnam. He assured us that "this airline" had seats reserved for us back to Okinawa and beyond when our tours in Vietnam were completed. He wanted no no-shows on those return flights. A Roman Catholic chaplain from our FMSS class then stood and asked for God's blessings and protection for these Marines on the airplane and all Marines in Vietnam.

With no more than an hour's daylight remaining, we landed in Vietnam at the incredibly busy Danang Air Base on 23 December 1965. When the C-130 finally taxied to a stop, we passengers were off-loaded. Typical of Danang's monsoon season, it was hot for a December day and oppressively humid. It was raining hard and relentlessly. We Medical Department officers and chaplains were "asked" to assemble in the shelter of the airplane's wing while the enlisted Marines, each in a poncho and a hel-

met, mustered in formation in the rain, entirely unprotected from the monsoon downpour.

Marines in a combat zone don't even begin to think about being politically correct. In fact, I'm not certain that the term "politically correct" had come into wide usage in 1965. At FMSS and during our pre-departure briefing on Okinawa, we were warned that the offensive word "gook" was never to be used in describing our Asian enemy. Some drill instructor of the future, who stood in the open as if he were completely oblivious of the torrential rain, "welcomed" us all to Vietnam. His first gesture was toward several North Vietnamese and Vietcong soldiers sitting blindfolded on the tarmac in the rain with their wrists and ankles bound with cloth. Using a bullhorn to talk over the unrelenting sounds of screaming jet engines, he pointed at the prisoners and shouted, "Marines, those are damned gooks! They are the enemy! If you don't kill them, they **will** kill you! Do I make myself clear?" He then did a 180 and pointed toward a cluster of permanent buildings on the opposite edge of the tarmac and shouted, "Marines, those air-conditioned school buildings over there are where members of the United States Air Force live while drawing hostile fire pay **and** inconvenience pay. You Marines will spend most of your nights in foxholes as long as you stay alive. Keep your asses low!"

Eventually a Marine with a clipboard wrapped in plastic led the Medical Department officers and chaplains from under the airplane's wing into one of the buildings. He divided us into several groups according to our destinations, and then told us we would just have to wait until a driver came to pick us up. Two dentists and I were destined for Charlie Med. We stood and wondered where our few precious belongings had disappeared to. There was no place to sit and every square inch of the floor was covered with liquid mud. The sole nourishment in sight was warm hyper-chlorinated water from a "water buffalo" to be drunk from a shared tin can. It was now dark, and countless flares lighted the distant skies. At Camp Pendleton, the flares had been part of an exercise conducted for our benefit by real (but friendly) Marines. Here, we didn't know the purpose of the flares, but we suspected that it was probably not an exercise.

After waiting several hours, a jeep, already carrying our missing belongings, with a Navy dental technician as a driver, picked up the three of us. He offered us a single warm grape soda to share. We then started the long trip in the rain along a dark road paved with nothing but mud and ruts and headed first through Dog Patch. "Here's were the prostitutes hang out." said our driver. Without stopping,we headed for the Division Surgeon's shack in the Third Marine Division headquarters area. Navy CAPT "Hap" Arnold acknowledged our arrival, took our orders to be endorsed and sent us several miles back down the same road in the same jeep to Charlie Med (Charlie Company, Third Medical Battalion, Third Marine Division (REIN)). His last words to me were, "LT Mahaffey, you have a long night ahead of you!"

The jeep had hardly stopped in front of Charlie Med's admin tent when I was met by LT Bill Self, a MSC officer I would later cross paths with throughout my Navy career. He took my briefcase and footlocker and placed them in the admin tent out of the pounding rain, then started walking me briskly to the operating rooms. "This is a busy night here. It's "Operation Harvest Moon" and the Marines are really taking a pounding."

The primitive operating room or OR that I entered was one of two at Charlie Med, and was like nothing I could have imagined. It was literally a sparingly air-conditioned plywood box surrounded by a tent, all of which was surrounded by 5-foot-high walls of sandbags. The inner walls were a sickly green, and the plywood floor gave in slightly to the weight of those who entered. The inner door was held shut by a strip of rubber cut from an inner tube. IVs would hang from hooks fashioned from electrical cable attached to vertical wooden 2-by-2s. A bare-bones field anesthesia machine provided nothing but nitrous oxide and oxygen.

On a porch-like area outside the door, there was a tiny scrub sink and a small electric autoclave, but most sterilization was done in large gasoline-fired autoclaves outside the nearby central supply tent. That central supply tent housed little more than several sheets of plywood studded with nails from which basic surgical instruments were hung. In the center of the tent was a table where instrument packs, reusable rubber gloves, surgical gowns, and drapes were prepared for sterilization. Saline solution for irrigation during surgery was also made here from scratch by filling empty IV bottles with hyper-chlorinated Marine potable water. After adding several salt tablets intended for human consumption, the bottles were then stoppered for sterilization.

Later, I would learn that the sandbags around the operating room tents were not to protect us in the OR, but rather to protect the rest of the compound from any grenades or whatever might explode while being removed from injured Marines. That type of catastrophe actually happened in sev-

eral medical outfits in Vietnam, but never at Charlie Med. But we were occasionally confronted by the potential for that disaster.

As I entered the OR, one of several busy OR techs working in muddy combat boots, utilities trousers, T-shirts, and surgical masks (but no surgical caps) asked me matter-of-factly if I was an anesthesiologist. I'm honestly not sure if or what I replied, but I was told that the next patient from the backlog of casualties was ready to be brought from triage to the OR. Doing my best to sound calm and professional, I directed, "OK! Give him a hundred of Demerol and six-tenths of Atropine," as had long been my pre-op routine stateside. I'm sure they either laughed or cringed in the triage tent (if my pre-op order even got that far), saying "What does that new guy think this is? A hospital?" Maybe they even called me a "FNG [F----n New Guy]." It was the last pre-op medications I ordered in Vietnam.

Original central supply, C-Med. Corpsman asleep in foreground.

I must say that the Marine supply system served us quite well for basic medical supplies, though we lived within the constraints of back ordered items and the Corps' traditional austerity. Surgical caps and scrub suits had obviously been overlooked when initial outfitting lists for medical battalions were prepared. Later those items arrived. I do not recall ever running out of essential medical items like spinal anesthesia sets, IV fluids, oxygen, etc.

Fortunately for me (and for that injured Marine), my first "combat anesthesia case" was a relatively simple one compared to the countless absolutely horrendous trauma cases our team would face in the weeks and months to come. He had a simple foot and ankle injury which was handled easily with a spinal anesthetic. This first easy case gave me the opportunity to adapt somewhat to my new surroundings and to get acquainted with a few members of the superb team I would work with during all of 1966. When the procedure was finished, we hand-carried the patient, who held his own IV bottle in the air, on a litter in the rain to the Recovery Room tent, which was located between the two sand-bagged ORs. It was a slightly larger plywood box with a struggling undersized air conditioner, surrounded by a tent, but it had no sand bags. Here I encountered CDR Steve James, one of Charlie Med's two orthopedic surgeons. He was writhing in pain while passing a kidney stone and incoherent from the morphine he had received. In dim light, corpsmen were tending to Steve and a number of post-op patients lying on knee-level folding canvas cots.

I didn't realize it then, but the medical team at Charlie Med was by far the very finest medical team I would ever be privileged to work with in my entire career as a physician. The shouted orders, the perpetual chaos, the pomposity, the romance, and the "drama" seen in movies and television sitcoms such as "ER," simply never existed at Charlie Med. Never! Back in the states, the movie M*A*S*H and its quirky medicine practiced by nonconformist surgeon-draftees would infuriate me. Each member of our sizable team knew his role, and very little was said even when we were swamped with casualties. Little needed to be said. Triage took place immediately as countless casualties were off-loaded from the helicopters, but more about triage later.

As would very frequently be the case, we did work all through that night, but fortunately for this newcomer to Charlie Med, the cases were relatively simple. After my first "combat case," someone asked me if I had eaten recently. Only then did I realize that I hadn't eaten since that unre-

markable sack lunch on the C-130. Eventually, after we had started the second case, a sandwich made of crudely-sliced Marine bread and a quarter-pound slab of Marine Spam slathered with mayonnaise, and a warm Coke showed up on my anesthesia machine. In stateside hospitals, I had certainly not been accustomed to eating Spam sandwiches in the OR! I guess that my look of surprise prompted the OR tech who delivered the food to respond. His eyes betrayed the unseen smile behind his surgical mask as he told me, "Around here when it's busy, you eat when you get the chance ." So, I turned my back to the stable patient momentarily and consumed my first Spam-based meal in Vietnam a few bites at a time.

Around dawn on Christmas Eve, 1965, we finished the backlog from that wave of casualties. The weather cleared somewhat, and Christmas Eve and Christmas Day were quiet days. I had the chance to meet more of my first-rate co-workers, and to get a better lay of the land.

Danang is on Vietnam's east coast on the South China Sea only a short distance south of the demilitarized zone, or DMZ, which then separated North and South Vietnam. To the north of Danang through Hai Van pass are Dong Ha, Phu Bai, and Hué, the ancient capital. To the south was Chu Lai. To the east of Charlie Med was an expanse of rice paddies extending to Danang Harbor. Danang City and Marble Mountain lay to the southeast. Charlie Med lay on a 15-mile road running from Danang City to the 3rd Marine Division Headquarters. Unbelievably, across the road from us was a Vietnamese stone quarry. While we were always prepared for "incoming rounds," that threat never materialized. But the unexpected explosions when the Vietnamese quarry workers dynamited solid rock kept us on edge, especially newcomers.

In December 1965, most of Charlie Med's hospital functions were still housed in tents, but new hardback buildings were being constructed one by one. The first night—Christmas Eve—I slept on a damp cot in LCDR Roger Houser's one-man tent since he was on emergency leave. When he returned, he proved to be one of the most professional, highly skilled combat surgeons I would ever meet. The next day—Christmas—I moved into a recently completed hardback structure housing two dentists, three general medical officers, and myself. That day, I purchased an ancient but functional electric fan, an immersion heater, and a mosquito net from a medical officer who had completed his 13 months in country and was packing out to return to the States. My bed was one of those folding knee-high canvas cots like those used in the recovery tent. That would be home for 13 long months. Absolutely plush compared to the way the Marines in the field would be living!

Suddenly reality hit me hard. I realized that, as the newest guy at Charlie Med, I could not return to the States in 13 months until after every last man I would meet this Christmas Day had completed his own 13- month tour and returned to the land of flush toilets and hot showers. This was my only brush with mild depression while I was in Vietnam.

Christmas Day was the most bizarre Christmas Day I had ever experienced. Established members of our team had received a few gifts from home to open, but no gifts had arrived from families for the newcomers. No tinsel and holly. And no family. In fact my family back in Ohio didn't even know where I was yet on Christmas Day. Christmas dinner in the mess hall was measurably better than Charlie Med's typical noon meals would prove to be, but it was nothing at all like home. I did attend Christmas Day services at the Charlie Med Chapel, but I was not overly impressed by the fundamentalist chaplain of a denomination other than my own. Timing was lousy, I thought to myself. I thought that I would have to spend two Christmases in Vietnam if I was going to be held to the standard 13-month Marine Corps tour.

On Christmas Day, I met CDR Almon C. Wilson, my battalion commanding officer. As a former line officer and aviator turned surgeon, he wasn't especially loved by fellow physicians but he was greatly respected by those of us who worked for him. He was indeed a fine commanding officer who ran the outfit sternly and professionally with exquisitely fair discipline. Out of courtesy, one or two of us usually joined him during meals in the mess hall, but in general, we left him to be about his own business. (To be continued)

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Listening to Your Audience to Justify and Manage Health Promotion Programs

David J. Reid M.S.
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The purpose of this article is to present a tool for health promoters to justify and manage programs based upon qualitative information. One of the difficulties for professional health promotion practitioners is managing and justifying their community-level initiatives. However, designing health promotion initiatives to serve communities and targeted populations, not just single individuals, is at the heart of public health orientation.(*1*) This article reviews how we are *listening to our audience*s at Naval Service Training Command (NSTC) Great Lakes to manage and justify a community-level health promotion campaign. A campaign is defined here as a strategic collection of organized activities to reach a goal. The campaign activities use various communication channels such as posters, slogans, special events, media messages, and existing educational efforts. The basis for this form of public health methodology may be found elsewhere.(*2,3*) Our work is not seeking to quantitatively *certify* the degree to which our campaign is changing health behavior. Future work may include quantitative analyses.

The campaign we have been working on is one that seeks to reduce the Navy recruits' adoption or resumption of tobacco use when they leave boot camp. A staggering number of recruits begin tobacco use after their nicotine-free boot camp weeks as indicated by the prevalence of tobacco use in young Navy enlisted.(*4*) To set the stage for this article, consider the questions that could be asked about a typical community-level health promotion program.

Mr. Reid, what is the target audience for the annual "Kick-Butts" program we host each year at our command? What drew you to the conclusion that a 5K run, procurement and distribution of 1,000 Kick-Butts water bottles, and a community-wide posting of yucky cancer posters was a way to reach, well, whoever you were trying to reach? I see that five people said they quit smoking during the program. That is super, but what about the other 15,000 tobacco users on base? Did you capture their interest or alienate them with your messages? You say you will track your five "quitters" after they PCS? Why and how would you do that? I thought our mission was culture change. How do these five people help you measure that? At what cost do you pursue them? All right, let me ask you this; let's assume five sailors quit. How many sailors started smoking this year? Has Kick-Butts affected that number and if so, how? Are we doing Kick-Butts next year and why? How will Kick-Butts change and why? Can it be done cheaper, i.e., without the water bottles, and will that diminish whatever it is we say we are accomplishing?

These types of questions can cause health promoters to leave their "calling" of targeting populations, and run for the safe harbor of patient education. We have not left our calling at Great Lakes and we feel we have found some better tools.

Management and justification of a program requires information. Program evaluation is a source of information. You will find that, regarding the types of evaluation, the definitions and the literature vary quite a bit. I will define how we are using them to avoid language barriers.

Formative Evaluation-Listening to the audience to be able to define the specific target and to design campaign messages that are personalized, of interest to them, relevant to them, understandable by them, adoptable by them, beneficial to them, are acceptable by their peers, memorable, consistent with their values, etc. This is done to improve current and future communication campaign strategies.

Impact evaluation- Listening to the audience to observe (formally or informally) the immediate effect of the communication campaign.

Outcome evaluation- Determining if the long-term organizational goals were met through changes in health indices.

For our ongoing campaign management, we have been listening to three audiences. We first assembled a group to represent base staff and had them speak about tobacco policy and resale issues. The reason for this meeting was to begin the ***formative evaluation*** process to develop a strategy to reduce student tobacco use. One of the most commonly proposed solutions for preventing tobacco use is some sort of heavy-handed policy decision. For example, "stop selling tobacco in the MWR and NEX," "Just make it a smoke-free base," "raise the price of tobacco so it becomes unaffordable," "eliminate smoke-decks and make them stand in the rain," and so on. Therefore, we initially needed to listen to the audience that controls policy. These people also live in, work in, and are accountable for the environment they create with policy decisions.

With this group we wanted to know if policy changes would be a reasonable expectation or useful in conjunction with a campaign. This group (STAFF-1) included CMCs, current tobacco-using staff, NEX tobacco resale manager, MWR e-club manager, and health champions. The results of the meeting are in figure 1. We agreed from this meeting that there is no be-all, end-all policy that would reduce tobacco use without quite a few serious problems to readiness. These problems include workforce inequalities and resentment due to reduced "rights," legal problems, perhaps recruiting problems, and others. Animosity exists on all sides of the tobacco issue, so, based upon what we heard from this audience, policy is probably not the best method to effect social change in student tobacco usage. The synergy of a tobacco campaign seems like a better plan. This meeting was a valuable piece of ***formative evaluation*** for our strategy. It also gave us good answers to use on this tricky and politically volatile subject .

The second audience we have been listening to is the A-school students who have recently graduated from boot camp. A small number of students (STUDENTS-1) were asked the questions, "*should* the Navy be tobacco free," and, "*could* the Navy ever be tobacco free?" They were asked these questions while waiting in the branch medical clinic. It was interesting to note that no students thought that the Navy *could be* tobacco free with some citing various versions of the health-police concept. Responses included "What's next, sugar-free Navy?" "A lot of good sailors will get in trouble." "People will always find a way to do it anyway." This feedback gave us further reason to believe that policy is not the best strategy to use in student tobacco use prevention. Again, this is ***formative evaluation*** contributing to campaign strategy.

Another student group of 116 A-school students (STUDENTS-2), was given a questionnaire in the galley. The first question was intended to provide an informal ***impact evaluation.*** The results indeed point to the possibility that there has been some positive impact from the recruit health lectures. In regard to ***formative evaluation*** the students may not understand how difficult it is to quit tobacco. They also seem to believe that a very high proportion of their peers use tobacco, perhaps an artificially high perceived norm. Surprisingly, students may feel tobacco use is just a choice with no specific reasons or meanings. Results of STUDENTS-2 are included in figure 2.

The third audience was recruits. This group (RECRUITS-1) was composed of 60 recruits who we interviewed or who answered questions on paper while they were waiting for dental care. It should be noted that prior to approval, it was critical for us to explain that the information we were getting was for the use of designing and improving communication campaigns, not to do a case study or research. We had a flowchart of interview questions reviewed by the Recruit Health Task Force. Please notice that accidentally using the terms "study" and "research" may bring a roadblock down on the would-be health promoter. We took the liberty of asking all of the tobacco users what they would do with the money they saved if they quit. The responses indicated that buying cars and supporting the family are how they visualize extra money. Responses also indicated that Sailors join the Navy for noble purposes such as earning college tuition, saving lives, and serving the country. They did not seem to have clear plans on how to attain these ambitions. When asked about plans for staying quit, none of the recruits had solid plans. There were many versions of "I just won't do it anymore." For many of the recruits, the worst thing about using tobacco and the best thing about quitting was athletic performance. There were a handful of cosmetic complaints about tobacco such as yellow teeth, bad breath, and stinky clothes. There was evidence in the responses of both STUDENTS-2 and RECRUITS-1 that indicate stress as a perceived reason for tobacco use. Some recruits indicated they knew people who were just waiting to get out of boot camp to buy a carton of cigarettes. However,

Figure 1 Tobacco Issues Roundtable NTC Great Lakes 3 June 2003 Brainstorming input from participants (STAFF-1)	
Pro's and con's of on-base tobacco resale	-Less expensive to member -Revenue supports MWR -Revenue is perceived as more important than health -Resale goes against Force Health Protection initiative -More disciplinary problems due to tobacco found in barracks -Good to have increased revenues -Perhaps greater food sales would occur in clubs without use & purchase of tobacco -Protects sailors by keeping them on base -People will buy it anyway, might as well keep the dollars within the Navy system -Tobacco revenue used for quality of life programs is ironic and unethical -Tobacco is a legal product to buy or sell -An E-1 pack-a-day smoker is wasting 25% of his take home pay on this habit
Smokers get more breaks	-Depends on the type of work. Outdoor workers don't take smoke breaks -Yes, smokers absolutely get more break time -Non-smokers can't just waste time on the job so why should smokers be able to leave -At hospital command smoke breaks could work out to perhaps 900 man-hours per day -Leadership should be aware/accountable for what their people are doing -There are non-smokers who accomplish nothing throughout the workday -Productivity has been shown to increase with breaks in the workday -I think smoke breaks decrease productivity and efficiecy -It's a fee country, a courtesy break for a snack, trip to the head, or cigarette are the same -It is unequal/unfair treatment if smokers get more breaks -Not however an EEO issue or an area of discrimination protected by law
Size, policy, and location of smoke decks	-Build multiple smoke decks to avoid fraternization -Smoke decks can be very expensive, perhaps $30K each -Smoke areas are littered, eye sores -Smoke decks can be "secured until cleaned" -Base policy not being followed regarding the 50' distance from entry/exit points -Could be used as a dual purpose space for dining, alchohol sales, etc. -Keeps smokers on base -Problems with separate HVAC indoor smoking due to facility workers being subjected to smoky environment -Enjoyable smoking areas seems like a quality of life issue to some -Keep smoke decks ugly/uncomfortable to de-glamorize -Shipboard smoke decks corral the smokers and increase the health risk -To make smoke deck far away or off compound causes longer and longer breaks -Comfortable smoke decks cause appearance of Navy condoning the use of cigarettes -Hey, I'm a non-smoker, I want a cedar gazebo to sit in too. Unequal treatment
Size, policy, and location of resale displays	-Normal product. It is up to the person doing the merchandising -Never bigger then the beer displays. It is a legal product -NEX personnel not familiar with cessation products? -Tobacco should be de-glamorized in same manner as alcohol -Cessation products should be sold near tobacco products -NEX says cessation products are currently near tobacco products -Should be no additional facilities to begin selling tobacco -MWR club does no advertising of cigarettes, they are out of sight behind counter -NEX sells cessation products but they are expensive, e.g. $50 for a box of gum
Group vs individual rights (smokers rights)	-Smoking is legal -You do not have the right to harm other people -Most smokers respect co-workers and family -Some smokers are adamant about their right to smoke -Policy outlawing public smoking is on the increase -Workers have the right to a tobacco-free workspace -Taxpayers rights, paying for DoD/VA medical costs and needing a ready force
Tobacco use as individualism/rebel spirit/fearless/recreation & control policies and resentment	-Sailors are smoke-free in bootcamp and start again in "A" school "because I can" -I'm young and buttletproof, tobacco can't hurt me -CMC concerned how many people failed the PRT run/can't breath/can't exercise -Begin smoking due to peer pressure and get addicted -Need to change policy -30% of smokers are said to have undiagnosed depressive illness -Corpsmen are the Navy role models and need to be tobacco free -11% of "A" school students initiate tobacco for first time because it is the culture -New No Smoking policy causes resentment -Smokers pass the PRT just fine. It is lazy-itis and Nintendo hurting the young Sailors -Younger Sailors want to do their own thing -There is resentment with policy regarding choice -Rebellion. Doesn't matter what you say, I am going to do it anyway -Some start smoking because it is not cool to be a non-smoker

we did not find anyone fitting this category. This may indicate a false perceived social norm due to embellished story telling.

We accomplished ***formative evaluation*** with the RECRUITS-1 interviews to assist in current and future strategy. There are already two ongoing poster initiatives, barracks health education centers, and health education lectures championed by Naval Dental Center (NDC) Great Lakes in the seventh week of boot camp. This is in addition to the wellness training during in-processing. Our RECRUITS-1 feedback gives us a basis for comparing notes and re-strategizing with the process owners of those initiatives. For instance, we might ask that education regarding *planning ability* be implemented in the recruit training curriculum or should be added to some part of NDCs lectures. We also learned some things about our audience that we did not know such as the desire for cars and more money for care of their families. This helps in our ***formative evaluation***. Perhaps a photograph of a nice car with "I bought this with my cigarette money" would work well in boot camp posters. Another part of the strategy might be to implement the same message within the local A-schools. Maybe at some point in the future the strategic messages could be forwarded to schools in other Navy locations so that the messages follow the sailors.

Plans for the immediate future involve doing more ***formative evaluation*** to determine the best channels of communication with students. We also want to ask how the tobacco quitters have quit and why the tobacco users started using again. There is a rapid 100 percent turnover in the student population here, which makes frequent queries practical. We do not plan to do ***outcome evaluation*** at our level due to the rapid turnover and relatively small numbers available for quantitative measurement. However, we feel that these same methods could be used at the system level to do ***outcome evaluation.*** One idea would be to do Navy-wide health surveys measuring changes in attitudes, beliefs, and behaviors, eventually searching for a causative correlation between health promotion campaigns and the changes.

This is a short example of how we have been *listening to audiences* to gain the information needed to create, justify, and manage programs. These methods will tell us if there has been immediate impact from our campaign. We gave a lengthy introduction to the concept to properly position the work to the readership. Three evaluation terms are defined for clarity, as there are inter-disciplinary differences in how these terms are used. Our feedback is qualitative although we feel the methods are a step forward in managing and justifying community-level health promotion initiatives. Based on a review of literature (*2,3*) we feel that the same methods could provide quantitative data and outcome evaluation if coordinated at the system level. We propose that system-level coordination could assist in continuity of strategies among Navy duty stations. We endeavor to continue to listen to specific audiences to formulate, strategize, and see impact from this and other campaigns.

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Ms. Thompson is Health Promotion Specialist at the same activity.

Figure 2
116 total completed questionnaires
(STUDENTS-2)
Circle all that apply

Health lectures in the first and seventh week of bootcamp helped me ____:	Responses
a. remain tobacco free after bootcamp	53
b. think of danger of tobacco	31
c. think of how much tobacco costs me in the long-run	24
d. I don't really remember the training	14
e. helped me want to quit but I started using tobacco again anyway	9
f. made me upset because it seemed like I was being preached at	6
Tobacco is:	**Responses**
a. used by most students	29
b. used by half of students	26
c. used by less than half of students	21
d. easy to quit if you want to quit	20
e. hard to quit if you want to quit	20
f. almost impossible to quit	7
g. hurting the Navy's readiness	22
h. a bad thing	46
i. a normal choice for some people	23
j. one of my military benefits in the commissary and NEX	1
Do you think tobacco has a "meaning" for users?	**Responses**
a. No, it is just something to do	41
b. Yes, it makes users feel independent	10
c. Yes, it makes special "rewards" during the day	10
d. Yes, it is an escape from stress	29
e. Yes, it is a way of belonging to a group	13
f. No, it is just an addiction	39

A Little Engagement at Vera Cruz

GEN Victoriano Huerta. President Woodrow Wilson. ADM Frank F. Fletcher. Throw in MAJ Smedley Butler and you have either got yourself one wild crap game or some of the leading players in the American occupation of Vera Cruz in 1914. By April of that year, the people of this port city in Mexico were already well versed in the art of being invaded. Ever since Hernán Cortés founded the city in 1519, Vera Cruz had become the most fashionable travel destination for any Spaniard, Frenchman, and American with sun, sand, and the conquest of Mexico on his mind. Well, in April 1914, the Americans were back in town, this time on a mission driven by wounded pride.

The "when" and "whys" of this questionable invasion begin in a little town called Tampico, about a year after the grisly slayings of Mexico's President Francisco Madero and Vice President Pino Suarez, and the shady ascendancy of the military dictator Victoriano Huerta. When a working party from USS *Dolphin* went ashore on 9 April 1914, a squad of Huerta's men arrested these Sailors for "trespassing." Even though they were released about an hour later with "expressed regrets," RADM Henry T. Mayo, Fleet Commander, demanded a formal apology from the Mexicans, along the lines of "publicly hoisting the American Flag in a prominent position on shore and saluting it with 21 guns." Mayo allotted 24 hours for this act. Huerta offered a note of regret but demanded that the order be withdrawn.

Soon, a finely brewed aroma of trouble wafted through the Washington office of Secretary of the Navy Josephus Daniels. Understandably, Secretary Daniels was irate with RADM Mayo for assuming too much authority. But Mayo also had two powerful allies, Secretary of State William Jennings Bryan and President Woodrow Wilson; both agreed with Mayo's action. After all, this, they each believed, was an issue of honor and Huerta should comply or face the unpleasant consequences. On 18 April Wilson issued the ultimatum:

"General Huerta is still insisting upon doing something less than has been demanded and something less would constitute an acknowledgment that his representatives were entirely wrong in the indignities they have put upon the Government of the United States. The President was [sic] determined that if General Huerta has not yielded by 6 o'clock on Sunday afternoon, he will take the matter to Congress on Monday."(*1*)

Photos courtesy of Medal of Honor Society

Navy Surgeon Middleton Stuart Elliott, Jr

When Huerta failed to act, the President delivered a special message to Congress. The House and Senate

overwhelmingly passed the subsequent resolution stating that "the President of the United States is justified in the employment of the Armed Forces of the United States to enforce the demands upon Victoriano Huerta for unequivocal amends to the Government of the United States for indignities committed against this Government by General Huerta and his representatives."(*2*)

The Atlantic Coast Fleet under the helm of Fleet ADM Frank F. Fletcher was directed by Secretary of the Navy Daniels to Vera Cruz, an important munitions debarkation point for Huerta forces and thus valued as a greater strategic target than Tampico. Even though President Wilson expected no resistance to the impending occupation, Daniels requested that RADM Mayo join Fletcher at Vera Cruz with his fleet that included the hospital ship USS *Solace*.(*3*)

On 21 April 1914, battalions, both Blue jacket and Marine, armed with bolt action Springfield rifles, landed early in the morning to be met with a powerful stench of a city without a sanitation service.(*4*) The naval force quickly organized and marched through narrow passageways toward the city center where a polyglot defense of 600 Mexican Federal troops, militia, and several hundred newly released and armed prisoners, called "stripers," awaited.(*5*)

Three from Vera Cruz

At first, the occupation met with an eerie lack of resistance. But the old real estate adage of "location, location, location" surely registered in someone's mind when the Americans reached the Customs House on Cable Lerdo and Morelos Streets, the so-called "bad corner." Huerta's Federal troops, so named Huertatistas, nesting in the House and on top of nearby hotels, began firing down upon the invaders. Five crack shot Sailors, led by an ENS Lowery from the USS *Florida* battalion, volunteered to expel the enemy within the House. After the volunteers made their way down the narrow alleyway between the House and the adjacent storehouse, they found themselves in the crossfire of machine gunners from atop the buildings. Two members of the volunteers were hit including a Coxswain J.F. Schumacher who was shot through the head. The volunteers quickly sought cover and Lowry screamed for help. HA1 William Zuiderveld, a 26-year-old hospital corpsman who had come ashore with the *Florida* landing party, heard the cries for aid and dashed through the hail of enemy gunfire to reach the wounded Sailor. Unaided, and oblivious to the chaos surrounding him, Zuiderveld bandaged Schumacher's head to staunch the hemorrhage. The Sailors continued to return gunfire at the Mexicans while Zuiderveld carried the bloodied Blue Jacket from the fray. Even though the volunteers expelled the enemy from the Customs House, and despite Zuiderveld's heroic efforts, Schumacher's wound was fatal.(*6*)

HA1 William Zuiderveld

To defend against the stubborn resistance and incessant sniper fire, the Americans erected trenches and barricades out of sacks of corn, coffee, and beans from nearby shops.(*7*) Over at the main pier, Navy Surgeon Middleton Stuart Elliott, Jr, a veteran of the Spanish American War, the Philippine Insurrection, and later World War I, was setting up a field medical station when bullets began raining down. Without regard for personal safety, Elliott ran to the firing line and helped to carry some of the wounded being brought out to the battle aid station. Over the course of the engagement, 63 wounded Sailors and Marines were treated under Elliott's supervision. Surgeon Elliott amazed more than a few with his "untiring efforts and effective work."(*8*)

By 1800 on the 21st, the firing grew less intense. During the night armed forces bivouacked in their respective positions. Some of the fiercest action would await them in the morning.

According to esteemed naval historian Jack Sweetman, the Mexican Naval Academy cadets in Vera Cruz were symbols of resistance going back to 1847 when, instead of surrendering to the invading American army led by General Winfield Scott, the cadets valiantly hurled themselves off a cliff. All Academy cadets knew this story by heart and they resolved to resist the Americans again, to the fullest. The cadets armed themselves, and buttressed the school's walls with furniture and mattresses. They were soon joined by Huertatistas with cannons.

On the morning of 22 April, Sailors from USS *New Jersey*, USS *New Hampshire*, USS *South Carolina*,

and USS *Vermont*, all surely unaware of the Academy's history, were marching through the streets when they came under heavy fire from the Naval Academy. As the U.S. Sailors ran for cover, Navy Surgeon Cary DeVall Langhorne unhesitatingly ran toward the wounded and retrieved a severely injured man from the attack.

Deck guns from USS *Chester* and USS *San Francisco* fired on the Academy soon smothering the resistance and forcing the cadets to flee or become just another battle fatality.(*9*) Within 36 hours of the Americans arrival, the resistance was dying. By 23 April it was dead. The Navy continued to occupy the city for another 2 weeks. In this time the occupiers suppressed lawlessness, re-established the city government, and raised an American flag prominently over the city. Shortly after they turned over the town to the U.S. Army. Huerta resigned in July.

Compared to any of the major battles fought in World War I, Vera Cruz was but a minor skirmish. Three days of action produced 90 wounded of whom 19 died—4 Sailors and 15 Marines. Interestingly, the conflict also produced 55 Congressional Medal of Honor recipients, the most ever for any single engagement. Among these were the controversial MAJ Smedley "Ole' Gimlet Eye" Butler and ADM Frank Fletcher, as well as three Navy medical men named Elliott, Langhorne, and Zuiderveld. Their deeds in Vera Cruz remind one of what RADM Jonathan Foltz is known to have said in a tribute to the common Sailor. To paraphrase, the Sailor's greatest ambition is to do his duty. May we all do ours just as well.

BUMED Archives

Navy Surgeon Cary DeVall Langhorne

Postscript

Middleton Elliot served as the commanding officer of Cañacao Naval Hospital, the Philippines. Promoted to rear admiral in 1933, he served as an Inspector for the Medical Department before his retirement on 1 November 1936. He died on 29 October 1952 and is buried at Fort Rosecrans National Cemetery in California.

Cary Langhorne joined the Naval Reserve in 1916. He retired from the Navy soon after World War I and settled on his estate in Upperville, VA. He died in 1948 and is one of four Navy Medical Department Medal of Honor recipients to be buried at Arlington National Cemetery.

William Zuiderveld served for 16 years as an enlisted pharmacist's mate. Six weeks before Japan's surprise attack on Pearl Harbor, he was "personally invited" back on active duty as a chief pharmacist's mate. He retired on 31 August 1945 as a lieutenant in the Hospital Corps (the Medical Service Corps was not established until August 1947.) He died in 1978 at age 90 and is buried at Fort Rosecrans National Cemetery in California.

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–Story by André B. Sobocinski, Assistant Historian, and staff writer for *Navy Medicine*, Bureau of Medicine and Surgery (M00H), Washington, DC.

Clinical Epidemiology and the Next Generation of TRICARE Contracts

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The summer of 2003 marked the fifth anniversary of the Navy Clinical Epidemiology Program (CEP). This program is a unique effort to facilitate the use of epidemiological principles and data to assist in optimizing Navy medicine. The importance of this program will increase as we look to the next generation of TRICARE contracts.

History

There were a number of key individuals involved in the birth of clinical epidemiology. CAPT Richard Buck, currently the commanding officer of Naval Hospital Pensacola, proposed this concept in 1996. With the advocacy of people such as RADM Robert Higgins, MC (Ret.), who served as the Deputy Surgeon General of the Navy, and RDML Robert D. Hufstader, the current Medical Officer of the Marine Corps, the concept developed a firm foundation of support. The first clinical epidemiologist was assigned to Naval Hospital Bremerton in 1998.

Clinical epidemiology applies principles of epidemiology to assist in optimizing medical services. A proper understanding and use of data and information maximizes the efficiency and effectiveness of healthcare programs leading to improved outcomes and better management of resources. Clinical epidemiology's combination of data and programmatic expertise allows this specialty to consult and collaborate with virtually every department within a healthcare organization. In particular, clinical epidemiology is a valuable tool for addressing disease management programs, clinical practice guidelines, JCAHO's ORYX®* core measurements, provider-specific performance measures, infection control, risk management, patient safety, credentials, and other key functions of a healthcare organization. A summary of roles and responsibilities for clinical epidemiology are listed below.

Table 1. Roles and Responsibilities of a Clinical Epidemiology Office/ Department

A clinical epidemiology office can provide support and consultation for:

• Managing data to include appropriate ways of collecting, analyzing, and utilizing data.

• Understanding and utilizing data programs such as Population Health Operational Tracking and Optimiza-

*ORYX® is the name of the Joint Commission's initiative to integrate performance measures into the accreditation process. The ORYX® initiative is a data-driven, continuous survey and accreditation process that complements JCAHO's standards-based assessment.

tion (PHOTO)* and the Population Health Navigator.

• Assisting the medical staff in identifying practice patterns and variations.

• Developing, implementing, and managing disease management programs and evidence-based clinical practice guidelines.

• Developing provider-specific performance measures.

• Assisting utilization management, case management, quality management, risk management, patient safety, and credentials.

• Collaborating on infection control, preventive medicine, and health promotion programs, particularly, as they relate to surveillance and response.

• Interpretation and utilization of JCAHO ORYX® data and special studies from the National Quality Management Program (NQMP).

The following examples illustrate the principles of clinical epidemiology in action: collecting and analyzing data from a population of patients and implementing a program to improve the health of the individual and the population.

Example 1. In 1998 a random record review at Camp Lejeune revealed that only 47 percent of the enrolled female population over the age of 50 had received a mammogram in the past 2 years. After implementing a local data warehouse, processes to extract data from the Composite Healthcare System (CHCS) and a patient contact strategy, the rate of mammogram compliance has increased to near 70 percent and continues to climb. Reminder letters are sent to enrolled women over age 50 in their birth month who have not had a mammogram in the past 18 months. Patient level data is also provided directly to the primary care team related to mammogram compliance on their enrolled population.

47 percent over the age of 50 had received a mammogram in 1998

70 percent over the age of 50 had received a mammogram in 2003

Example 2. In 1999 Naval Hospital Pensacola implemented a clinical practice guideline for acute dysuria which included a nurse triage protocol. This effort was coordinated by the clinical epidemiology office and several members of the medical staff. The benefits of this disease management program included improved quality of care and resource management. For example, from October 1999 through March of 2002, there was a 36 percent reduction in pharmacy and lab costs for an estimated savings of $11,690.

Example 3. The Diabetes Management Program was established at Naval Hospital Bremerton (NHB) in April 2001. The program has identified about 1,000 diabetics at NHB that are cared for in a multi disciplinary team approach. In a little over 2 years the results have been outstanding. The outcomes at NHB are better than 90 percent of all health plans that report to the National Committee for Quality Assurance in all of the outcomes measured for diabetes. A list of the measurements and the improvements that have occurred since the program began are in the Example 3 table.

The above examples represent interventions involving a clinical preventive service, an acute illness, and a chronic disease—an important balance as we seek to prevent diseases, intervene early in illnesses, and mitigate the effects of chronic diseases. Many other disease and injury prevention and management programs and initiatives have been implemented at medical treatment facilities (MTFs) throughout the Navy—and many more can be. These efforts are helping to improve the quality of care given to our beneficiaries and the management of our resources. Clinical epidemiology has played a vital role in coordinating, facilitating, and supporting many of these efforts.

Table 2. Clinical Epidemiologists at U.S. Navy Medical Treatment Facilities

Medical Treatment Facility	Clinical Epidemiologist in Billet
National Naval Medical Center	No
Naval Hospital Bremerton	Yes
Naval Hospital Camp Pendleton	No
Naval Hospital Great Lakes	Yes
Naval Hospital Jacksonville	Yes
U.S. Naval Hospital Okinawa	No
Branch Medical Clinic Pearl Harbor	Yes
Naval Hospital Pensacola	Yes
Naval Medical Center Portsmouth	Yes
Naval Medical Center San Diego	Yes

*A new metrics driven datamart designed to provide MHS personnel easy access to performance measurement information identified by the Tri-Service Metrics Workgroup in managed care, readiness, and wellness/prevention.

Example 3	Percent April 01	Percent May 03
HgbA1c tested in past 12 mos	84	92
HgbA1c>9.5 percent (lower is better)	17	15
LDL tested in past 24 mos	75	98
LDL <130 in past 24 mos	55	76
Dilated retinal exam in past 12 mos	60 (Nov 01)	75
Microalbuminuria tested in past 12 mos	68 (Dec 02)	75

Current Status

The Navy CEP is managed by the Navy Environmental Health Center (NEHC) in Portsmouth, VA. NEHC has provided leadership through training, marketing, and recruitment. Every year NEHC sponsors medical informatics training for those working in clinical epidemiology.

Currently, 7 of the 10 clinical epidemiologist billets located in Navy MTFs are filled (Table 2). Most of these positions are occupied by physicians from the general preventive medicine community. However, Medical Corps officers from any specialty who have a graduate degree in public health or a comparable degree are eligible for these billets.

The Future

There are many exciting challenges in the future. These challenges are currently being addressed by the clinical epidemiology leadership and include:

• *Clarifying the purpose and role of clinical epidemiology.* The concept and implementation of clinical epidemiology needs to be clearly presented to senior leadership and the medical and administrative staffs of MTFs. An improved model and more aggressive marketing will help to communicate the potential value of this program.

• *Organizational Placement.* MTFs have placed the clinical epidemiology function in different areas in the organization. Ideally, wherever it is placed, a clinical epidemiology office or department should be allowed to serve as a consultant throughout the healthcare organization and as a bridge between administrative and clinical services.

• *Manpower.* The Navy CEP needs a source for manpower. As a part of a specialty community, such as preventive medicine, the program could compete for training billets. Also, civilian and contracted epidemiologists and healthcare data analysts are a source of manpower for clinical epidemiology offices and departments.

• *Training.* Clinical epidemiology is a relatively new and revolutionary discipline. Therefore, it is essential to provide "crest of the wave" training in evidence-based medicine, healthcare epidemiology, healthcare management, and data management and analysis to those working in this field.

• *Leadership.* NEHC will continue as the program manager leading in program development, training, and marketing. Working with groups, such as the BUMED Evidence-Based Health Care Advisory Board, Healthcare Support Offices, and specialty communities, such as preventive medicine, can facilitate the development and the contributions of the Navy CEP.

Summary

The CEP is only 5 years old. Yet, it has demonstrated an ability to improve the performance of Navy MTFs by using epidemiological skills to help build and manage programs throughout the healthcare spectrum. With greater changes to the healthcare system on the horizon, clinical epidemiology can become an increasingly valuable resource to the future of Navy medicine. As CAPT Buck observes, "As successful as the clinical epidemiology program has been in its first 5 years, its services will be even more valuable as we enter into the next stage of TRICARE contracts." ❑

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Patient Confidentiality and Sexual Health

A Discussion for Health Care Providers

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In addition to the obvious challenge of helping a person reduce their health-risk behavior, military healthcare professionals who treat and counsel Sailors and Marines for sexual health conditions also face some unique additional challenges. These challenges include confidentiality and the conflict that can arise between a healthcare provider's need for personal information, and the healthcare provider's legal and ethical requirements to report behavior that may be illegal, harmful, or detrimental to the naval service.

Privacy is understandably important to every patient, particularly regarding sexual health. Military patients may also be concerned with perceived work-related implications of their condition. These concerns may be heightened for people who are married, those in leadership positions, those in highly sensitive job positions, those who are concerned their sexual behavior may violate the Uniform Code of Military Justice (UCMJ), those who personally know the shipboard "doc," or those who simply fear their privacy will not be protected.

Examples of conditions that may communicate a lack of privacy are the "STD clinic" sign or the STD clinic time-block, real or perceived "Command access" or mishandling of sensitive medical records, and real or perceived unauthorized release, or idle discussion of personal information.

Another example is the perception among some Sailors and Marines that they will be punished for seeking sexually transmitted infection (STI) treatment. This perception holds that some medical professionals advocate discipline as a "cure" for repeated STIs. Typical anecdotes may be the Sailor who was denied liberty call for multiple STIs during a cruise, the Marine who is told "You know—if this happens again we'll report it to your commanding officer," or the leader who announces to a crew that they "will not pick up any STIs on this float—or else." These perceptions persist even though the Armed Forces Epidemiological Board specifically discouraged the use of punishment to control STIs over three decades ago.(*1*,*2*)

When Sailors and Marines perceive a lack of privacy or fear discipline for their infection, STI prevention and control is hindered. Some people may seek treatment from a civilian source. Others may self-treat with medications purchased over-the-counter in foreign ports or may try folk remedies. They may delay treatment, or avoid seeking treatment altogether. This could result in asymptomatic carrier states, which may spread the untreated STI to others, or result in more serious complications such as pelvic inflammatory disease (PID) (*3*) or latent syphilis. Some people might purge their medical records of documentation of previous STIs, thereby impeding follow up treatment. When Sailors and Marines do not seek care from our military healthcare system, we lose the opportunity to provide appropriate treatment, prevention counseling, and partner referral. These unique challenges can and must be overcome. Military medical professionals are most effective when their clientele perceive them as trusted healers and helpers.

When is the healthcare worker required to disclose information shared by a patient during treatment?

Article 1137 of U.S. Navy Regulations require persons in the naval service to report to superior authority all offenses under the UCMJ that come under their observation. Violation of this article is punishable under the UCMJ. The guidance that has been provided by the Deputy Assistant Judge Advocate General (criminal law) is that the term "observation" should be strictly interpreted, i.e., it is limited to actual observed (first hand knowledge) offenses and that hearsay reports (verbal accounts) are not actionable. That does not mean hearsay disclosures can't be reported, but that a failure to do so is not a violation of Navy regulations.(*4*)

Regarding homosexual conduct, a 1998 DOD report concludes "*It has been alleged that DOD doctors . . .are required to, and do, disclose confidential communications concerning homosexual conduct to commanders. We found that none of the Services require healthcare professionals to report information provided by their patients, unless, in the judgment of the healthcare professional, it is necessary to do so in order to protect the patients or to ensure the safety or security of military personnel or the accomplishment of the military mission.*"(*5*)

Specific requirements for a healthcare worker to report disclosures by clients include cases of suspected child physical or sexual abuse, when clients express threats to cause harm to themselves or someone else, or if it is clear to the healthcare worker that clients are unfit for service.

Concerning sexual partner referral, spouses will always be notified of the HIV-positive status of a service member.(*6*) Regarding other STIs, and non-spousal sexual partners of HIV positive patients, healthcare workers will notify only named sexual partners of their exposure, but will not divulge the name of the patient to the partner.(*6,7*)

The Privacy Act and the Health Insurance Portability and Accountability Act (HIPAA) govern access to and release of health/medical information. DOD implementing guidance for these acts can be found in DOD 5400.11-R, "DOD Privacy Act Program," and DOD 6025.19-R, "DOD Health Information Privacy Regulation." In general, personally identifiable health information of individuals shall not be used or disclosed except for specifically permitted purposes (e.g., law enforcement, military mission activities, and public health to name a few) and must be the minimum amount of information necessary to accomplish a valid use or disclosure purpose. Any questions on the release of health information should be referred to the military treatment facility's (MTF's) privacy officer.

The Manual of the Medical Department (MANMED) provides additional guidance for medico-legal issues including entries by healthcare professionals and access/release of medical information.(*8*) Article 16-37 of the MANMED states "*Access is restricted to persons with a legal need to know about the information contained in the medical record . . .*" Additionally, the manual states, "*The following information cannot be released without the patients' informed consent . . . (b) Never release, for a routine inquiry, prognosis or sensitive information about the admission of the patient such as . . . venereal or other sexually transmitted diseases.*" Article 16-9 restricts access to medical records to authorized medical service personnel and has specific exceptions to access specified within this article.

The authority to release medical information of an active duty service member to his or her commanding officer is provided in Navy Regulations Article 0820, Welfare of Personnel. This article directs that the commanding officer maintain a satisfactory state of health and physical fitness of the personnel under his or her command. The release of medical information is crucial in the ability of the commanding officer to fulfill this obligation. It is noted that the commanding officer is also bound by the laws referenced above in the use and any further disclosure of an individual's medical information.(*4*)

Access to medical records for non-healthcare-related purposes is not unique to the military. Civilian authorities can similarly access the records of civilians by subpoena and/or court order, in accordance with state and federal laws.

Documenting and Reporting "Misconduct" in a medical record is addressed in the MANMED Article 16-38, which states "*U.S. Navy Regulations, articles 1123 and 1124 require that Naval personnel be advised in writing when entries are made in their medical records relative to disease or injury attributed to misconduct, or indicating the use of intoxicants or habit forming drugs to a degree presumed to disqualify the member physically, mentally, or morally for performance of duties.*" Additionally, it states to "*seek legal advice regarding*" these matters.

Regarding the confidentiality of the epidemiological interview of HIV-positive active duty members, "*Information obtained from a service member during or as a result of an epidemiologic assessment interview may not be used against the service member in a court martial; nonju-*

dicial punishment; involuntary separation (other than for medical reasons); administrative or disciplinary reduction in grade; denial of promotion; an unfavorable entry in a personnel record; bar to reenlistment; and any other action considered by the Secretary of the Navy to be an adverse personnel action. The term epidemiological-assessment interview means: that part of the medical assessment of an HIV-1 positive individual where the questioning of the member is for the direct purpose of obtaining epidemiologic or statistical information regarding the occurrence, source, and potential spread of the infection."(*6*)

An exception exists for HIV positive active duty members who are subject to disciplinary action under the UCMJ and/or administrative separation for failure to comply with a written "preventive medicine order" (PMO).(*9*) This order states:

"Prior to engaging in sexual activity, or any activity in which your bodily fluids may be transmitted to another person, you must verbally advise any prospective sexual partner that you are HIV positive and the risk of possible infection . . . . If your partner consents to sexual relations, you shall not engage in sexual activities without the use of a condom . . . . You must advise your potential partner that the use of a condom does not guarantee that the virus will not be transmitted."

SHARP (Sexual Health and Responsibility Program), while not policy makers or medical-legal authorities, suggests these guidelines for healthcare workers:

• Provide for the healthcare needs of your patients, make appropriate notations in the medical record, and maintain confidentiality of the medical record in accordance with laws and regulations.

• Be cognizant of the fact that there is a process for law enforcement authorities to access medical records when they have due cause, and that providers can be called to testify regarding any entry they make in the medical record.

• There should never be a need for the healthcare worker to make any standard opening statements about liability or Miranda-like warnings regarding the information patients might share. Do not open sessions with "warnings" or "promises." Instead, be prepared to answer specific questions the patient may ask regarding what is written, who has access to the record, and how the patient's personal medical information is handled and protected in the process of partner notification and disease reporting.

• Regarding requests for information from medical records, refer the requestor to the MTF medical records privacy officer, where policies and procedures exist to ensure appropriate protection and release of personal medical information.

• Consider that the use of discipline as a "cure" or prevention for STIs can damage a service member's trust in the healthcare system and may reduce health-seeking behavior.

• Know your state laws relative to reporting and partner notification.

• Seek clarification from your chain of command and its legal advisors when you need it.

Perception equals reality. Navy medicine cannot assist patients who do not seek care. Military medical professionals are most effective when their clientele perceive them as trusted healers and helpers.

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Book Review

The Age of Miracles by Guy Williams. Academy Chicago Publisher, Chicago, IL. 221 pages. 1981.

In *The Age of Miracles*, Guy Williams squeezes in an historical wealth of biographical sketches and tales of scientific discoveries that are often shocking, sometimes humorous, and always fascinating. Each chapter is a theme in 19th century medicine, e.g., Birth of Tropical Medicine, Going to Hospital in the Nineteenth Century, Anesthetics, Antiseptics, and Birth and Infancy in the Nineteenth Century.

The first chapter highlights the careers of the Hunter brothers, John and William, whose revolutionary teachings in anatomy at the University of Edinburgh Medical School helped to produce some of the most brilliant men of 19th century medicine. Among these are Dr. John Syng Physick, the so called "Father of American Surgery" and William Hewson, a President of the College of Physicians in Philadelphia, PA. Williams makes it clear that scientific progress is built upon the ideas and discoveries of those who came before, be it Aristotle or John Hunter. However, cloaked beneath Hunter's genius and his steadfast pursuit of surgical advancement, was the hobgoblin of exploitation. Due to the paucity of good anatomical subjects at medical schools some fiendish operators, known as "body snatchers" or "resurrection men," took to stealing freshly dead bodies from graveyards and selling them to teachers of anatomy. Notable among these fiends were William Hare and William Burke (the famed body snatchers immortalized on celluloid), who took to luring the unsuspecting to a lodging house, getting them drunk, smothering them, and then selling their bodies to science. Even the great John Hunter was not above the hideous act of grave robbing in the name of science. He bribed an undertaker to get the body of an Irish giant named Charles Byrne. The tall man's skeleton was put on display at a medical museum where it can still be seen today.

In the chapter entitled Antiseptics, Williams tells the interwoven tale of Joseph Lister and Louis Pasteur. These men worked at a time when infection was considered the result of the "miasmic influence" (i.e. "bad air"). Both Lister and Pasteur were forward thinking men of science who overlooked the prevalent theories about micro-organisms. But without Pasteur's discovery that organic decomposition was not caused by bad air or by the spontaneous generation of germs but by living organisms carried through the air, Lister would not have revolutionized the world of medicine with use of antiseptic surgical spray. Pasteur had shown that deadly micro-organisms could be eradicated through heat and chemical means. Lister pursued the latter. He came across the newly developed liquid called "carbolic acid" that had already found use as a disinfectant in France. Although Lister had greatly reduced the mortality rate due to sepsis in surgery, it was an American doctor named Halstead who suggested that surgeons and nurses use rubber gloves, a Polish doctor named Miculicz who recommended facial gauze, and a German doctor named Bergmann who suggested sanitization of surgical rooms with sterilization steam.

Guy Williams makes it clear that dynamic individuals like Florence Nightingale and Dr. Philippe Pinel were responsible for the paradigm shift in 19th medicine. Hospitals and mental asylums were brutal battlegrounds where people suffered terribly before compassionate, humanistic care of the sick was instituted. Pinel, as the director of the famed mental asylum Salpêtrière, saw how the mentally disturbed were treated like third rate prisoners, shackled in chains and kept in cold cells to be forever gnawed upon by hungry rats. Dr. Pinel proposed that patients needed to be released from their fetters and given more fresh air and liberty. The mental health community owes much to Pinel and his successor Jean-Martin Charcot, but there are many others who the author overlooks in *The Age of Miracles*, including America's first great psychiatrist, Dr. Benjamin Rush. Rush had proposed counseling and music therapy for the mentally ill at the very beginning of the 1800s.

The *Age of Miracles* is a short read, just 221 pages, and is a wonderfully fresh introduction to the history of 19th century medicine. However, if you are wishing to learn more about the heritage of American medicine and U.S. military medicine during the same era, there are many worthy books you may wish to consult first. ❑

—André B. Sobocinski, Assistant Historian, and staff writer for *Navy Medicine*, Bureau of Medicine and Surgery (M00H), Washington, DC.

Navy Medicine 1943

BUMED Archives

PhM3c Ruth Nellis tests the hearing of Marine CPL George Evans at NNMC Bethesda.